

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3754

CERTIFICATE OF DEATH

03743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b all her life X Berlin	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.O. Box 53		d. STREET ADDRESS P O Box 53	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mamie Middle A Last Bowen		4. DATE OF DEATH Month 3 Day 13 Year 19 59	
5. SEX FM	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/1898
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Doane		14. MOTHER'S MAIDEN NAME Mary ? Doane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Howard Bowen, Berlin, Md Box 53	
17. INFORMANT Howard Bowen, Berlin, Md Box 53		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas with metastases 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic cholecystitis & cholelithiasis INTERVAL BETWEEN ONSET AND DEATH 9 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-12 , 19 59 , to 3-13 , 19 59 , that I last saw the deceased alive on 3-13 , 19 59 , and that death occurred at 6:35 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ivory N. Sully, Jr.		ADDRESS (Street, city or town, state) Berlin Md	
DATE SIGNED 3/17/59			
PHYSICIAN'S NAME (Type) Dr. Ivory Sully, Jr.		Berlin, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/1959	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart		ADDRESS Funeral Home, Salisbury, Md	
24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

3755 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Pomoke</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
c. LENGTH OF STAY IN 1b <u>19.58</u>		d. STREET ADDRESS <u>R 203</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Garry Wayne Doughty</u> First Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 19, 1958</u> mo. <u>12</u> yrs. <u>5</u>
9. AGE (In years last birthday) <u>5</u> yrs. <u>3</u> mos. <u>5</u> days		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Francis Doughty</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Elizabeth Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Ruth Elizabeth Doughty</u>		Address <u>Pocomoke MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia probably</u> 492x DUE TO <u>Upper Respiratory Cold virus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>[redacted]</u> DUE TO <u>[redacted]</u> (c) <u>[redacted]</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>[redacted]</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>[redacted]</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N. E. Sartorius Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-26-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Burton</u>		22d. LOCATION (City, town, or county) (State) <u>Melfa, VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u> ADDRESS <u>new church, VA.</u>		24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>C. J. [redacted]</u>			

4000162XV6

1. *Medical Examiner's Certificate of Death*

3751

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				c. LENGTH OF STAY IN 1b 14 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) 8 Clementine Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last OCA ELIZABETH EVANS				4. DATE OF DEATH Month Day Year March 4 1959			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 25, 1893	
9. AGE (in years last birthday) yrs. 66		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William E. Wise		14. MOTHER'S MAIDEN NAME Gracie Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Grace Marshall, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 463x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis of left leg. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 10 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteoarthritis @ Medualltion							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/25/59 , 19 59 , to 3/4/59 , 19 59 , that I last saw the deceased alive on 3/4/59 , 19 59 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Cecil A. Duverney M.D.				ADDRESS (Street, city or town, state) 801 - 4th St., Pocomoke			
DATE SIGNED 3/7/59							
PHYSICIAN'S NAME (Type) Cecil A. Duverney							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-59		22c. NAME OF CEMETERY OR CREMATORY Cool Spring Cemetery		22d. LOCATION (City, town, or county) (State) Girdletree, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Therese Watson				ADDRESS Pocomoke City, Md		24a. REC'D BY REGISTRAR DATE MAR 11 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03747

3757

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b ALL her life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julia Middle Ann Last Foreman		4. DATE OF DEATH Month 3 Day 25 Year 1959	
5. SEX F.M.	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-1876
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK LEONARD		14. MOTHER'S MAIDEN NAME ARLANTA TIMMONS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. CHARLES FOREMAN JR.		Address BERLIN, MD, Rt #3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Cerebral thrombosis DUE TO (b) Hypertensive Cardiovascular disease DUE TO (c) 5 yrs 4 mos PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 20 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-29 , 19 53 to 3-25 , 19 59 , that I last saw the deceased alive on 3-25 , 19 59 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ivory U. Suilly, Jr. M.D.		ADDRESS (Street, city or town, state) Berlin, Md DATE SIGNED 3/28/59	
PHYSICIAN'S NAME (Type) IVORY U. SUILLY, JR. M.D.		BERLIN, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-28-59	22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	22d. LOCATION (City, town, or county) (State) NEWARK, MD
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Stewart Funeral Home, Salisbury, Md		24a. REC'D BY REGISTRAR APR 2 '59 24b. REGISTRAR'S SIGNATURE Arthur S. ...	

CERTIFICATE OF DEATH

1915

FILE NO.

Wm. Nelson

Wm. Nelson

Wm. Nelson

Wm. Nelson



3756

CERTIFICATE OF DEATH

Reg. Dist. No.

03746

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE HAROLD GOODMAN</u>				4. DATE OF DEATH Month Day Year <u>MAR. 4 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 26, 1888</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHICKEN PLANT ARDMORE PA</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE O. GOODMAN</u>				14. MOTHER'S MAIDEN NAME <u>ANNA SLATER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-18-4091</u>		17. INFORMANT Address <u>MRS. G. H. GOODMAN BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Cardiac asthma</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1-1</u> 19 <u>55</u> to <u>3-4</u> 19 <u>59</u> , that I last saw the deceased alive on <u>3-1-59</u> , 19 <u>59</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford E. Schott</u>				DATE SIGNED <u>BERLIN MD.</u>			
PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT M.D. BERLIN, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/6/59</u>		<u>EVERGREEN</u>		<u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage Berlin MD</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u>	

3758

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>P.O.</u>	
3. NAME OF DECEASED (Type or print) <u>Paul Clifford Johnson</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1942</u>
9. AGE (In years last birthday) <u>16</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Jones</u>		14. MOTHER'S MAIDEN NAME <u>Essie Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Essie Johnson</u>		Address <u>Bishop, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>744.1 Congestive heart failure</u> DUE TO (b) <u>Muscular dystrophy</u> DUE TO (c) <u>1 yr. 11 mos.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-5-1957</u> to <u>3-5-1959</u> , that I last saw the deceased alive on <u>3-5-1959</u> , and that death occurred at <u>10:45 AM</u> , from the cause and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V. Sullivan, M.D.</u>		ADDRESS (Street, city or town, state) <u>Baltimore, Md</u>	
PHYSICIAN'S NAME (Type) <u>Henry V. Sullivan, M.D.</u>		DATE SIGNED <u>3/6/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Mar 8, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Baltimore City, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

103741

Reg. Dist. No.

3759

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>Church</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>J.</u> Middle <u>Sauers</u> Last		4. DATE OF DEATH <u>March</u> Month <u>27</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-1897</u>
9. AGE (In years, last birthday) <u>61</u> 1/4		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Peter J. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Lucie Evans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SPECIAL SECURITY NO. <u>314-32-1064</u>	
17. INFORMANT <u>Mr. William Sauers</u> Address <u>Snow Hill, MD</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased Intracranial Pressure</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic Breast Carcinoma</u> DUE TO <u>Breast Carcinoma</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1, 1953</u> to <u>March 27, 1959</u> , that I last saw the deceased alive on <u>March 27, 1959</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Bay St. Snow Hill, Md.</u> DATE SIGNED <u>3-28-59</u>			
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.		PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>March 30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bates Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Emms</u> ADDRESS <u>Snow Hill, MD</u>		24a. REC'D BY REGISTRAR <u>MAR 31 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



3752

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 Sixth Street		d. STREET ADDRESS 209 Sixth Street	
3. NAME OF DECEASED (Type or print) First CORA Middle M. Last LONG		4. DATE OF DEATH Month March Day 4, Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 19, 1882
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Irvin Mentzer		14. MOTHER'S MAIDEN NAME Rebecca Slippy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs A. J. Duncan, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 4.23X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Asthma 2. Generalized Atherosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 8, 1957, to Mar. 4, 1959, that I last saw the deceased alive on Mar. 4, 1959, and that death occurred at 4:52 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles W. Trader M.D.			
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D. 302 Market St., Pocomoke City, Md. 3/5/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-59	
22c. NAME OF CEMETERY First Baptist		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry B. Watson		24a. RECORD BY REGISTRAR MAR 9 1959	
ADDRESS Pocomoke City, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3760

Items 1-4 11-12 29 30 31-32 59 et

CERTIFICATE OF DEATH

03751

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whalequellles</u>				c. LENGTH OF STAY IN 1b <u>9 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>R-7A.</u>			
3. NAME OF DECEASED (Type or print) First <u>Y. Cronica</u> Middle <u>Rosa</u> Last <u>Mahoney</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/14-1966</u>	9. AGE (in years last birthday) <u>58</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u>	
13. FATHER'S NAME <u>John Mahoney</u>				14. MOTHER'S MAIDEN NAME <u>Wm. H. Brady</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>104-111-1000</u>		17. INFORMANT <u>Leonard Mahoney</u> Address <u>Whalequellles</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Attack</u>							<u>1 week</u>
DUE TO (b) <u>Chronic Myocarditis</u>							
DUE TO (c) <u>lying cause last.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3-2-</u> 19 <u>57</u> , to <u>3-7-</u> 19 <u>59</u> , that I last saw the deceased alive on <u>3-2-</u> 19 <u>59</u> , and that death occurred at <u>3 A</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas R Law</u> M.D.				ADDRESS (Street, city or town, state) <u>Burien Md</u> DATE SIGNED <u>3-7-1959</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/10/59</u>		<u>St. Mary</u>		<u>Coxsackie N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>Pocomoke City Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3761

CERTIFICATE OF DEATH

03752

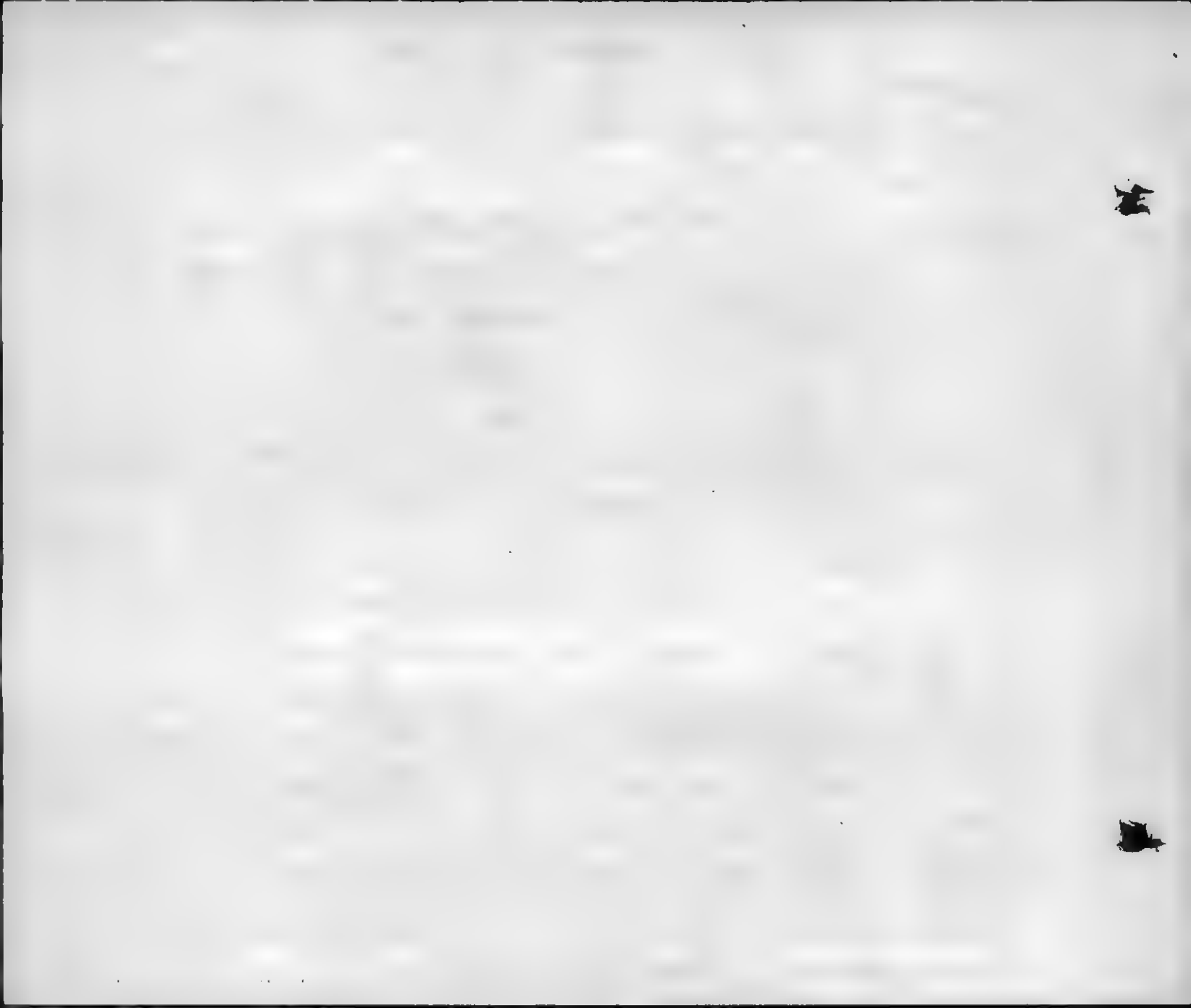
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Chesapeake</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Chesapeake</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joe</u> Middle <u>Louis</u> Last <u>Mills Jr.</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1959</u>	
9. AGE (in years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Stockton, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ind.</u>	
13. FATHER'S NAME <u>Joe Louis Mills Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. Joe Louis Mills Jr., Stockton, Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>762.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/2</u> , 19 <u>59</u> , to <u>3/3</u> , 19 <u>59</u> that I last saw the deceased alive on <u>3/2</u> , 19 <u>59</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John M. Bender</u> M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>John M. Bender M.D.</u>				ADDRESS <u>104 Bay St. Snow Hill, Ind.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 4/59</u>		<u>Benificial Society</u>		<u>Stockton, Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Dennis</u>				ADDRESS <u>Snow Hill, Ind.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3762

CERTIFICATE OF DEATH

03753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BISHOP		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BISHOP	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS R.F.D.	
3. NAME OF DECEASED (Type or print) ELSIE First ANN Middle SELBY Last		4. DATE OF DEATH MARCH 6 19 59 Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 11, 1880
9. AGE (In years, months, days) 79 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES TURBBS		14. MOTHER'S MAIDEN NAME MARY ANN ZULLEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 1	
17. INFORMANT DANIEL SELBY		Address BISHOPVILLE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease (c) Myocardial insufficiency			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 9 , 19 58 , to March 6 , 19 59 , that I last saw the deceased alive on March 5 , 19 59 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Miss Hanson M.D.		ADDRESS (Street, city or town, state) Beggsboro Del. DATE SIGNED 3-6-59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Buried	3/8/59	St. O. O. S. F.	Bishopville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edwin Whaley		24a. REC'D BY REGISTRAR Arthur L. Hanson	
ADDRESS Seaboard Rd.		24b. REGISTRAR'S SIGNATURE Arthur L. Hanson	
DATE MAR 10 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Death: Page 4

TC

CERTIFICATE OF DEATH

Reg. Dist. No.

3753

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) 12 Second Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MILTON L. VEASEY		4. DATE OF DEATH Month March Day 27 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1877
9. AGE (In years last birthday) 81 yrs.		10. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer and Banker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas J. Veasey		14. MOTHER'S MAIDEN NAME Marietta Richards	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. 216-12-1835	
17. INFORMANT Mrs May Y. Veasey, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes Years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (a) Pulmonary Edema; (b) Stokes-Adams Syndrome		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 9, 1955 , to March 27, 1959 , that I last saw the deceased alive on Mar. 27, 1959 , and that death occurred at 640a. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles W. Trader		ADDRESS (Street, city or town, state) 302 Market St., Pocomoke, Md.	
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.		DATE SIGNED 3-27-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-29-59	22c. NAME OF CEMETERY Bethany Methodist	22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Watson		24a. REC'D BY REGISTRAR DATE MAR 30 '59	
ADDRESS Pocomoke City, Md.		24b. REGISTRAR'S SIGNATURE William J. K.	

MEDICAL CERTIFICATION

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of the death. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1925

Name of Deceased		Age		Sex		Race		Date of Death	
John Doe		45		Male		White		Jan 15, 1925	
Place of Birth		Cause of Death		Occupation		Marital Status		Signature of Physician	
New York City		Heart Disease		Teacher		Married		J. Smith	
Place of Death		Date of Burial		Burial Place		Name of Minister		Signature of Minister	
New York City		Jan 20, 1925		St. Paul's Church		Rev. J. Doe		J. Doe	
Name of Informant		Relationship to Deceased		Signature of Informant		Date of Statement		Signature of Registrar	
John Doe		Son		J. Doe		Jan 16, 1925		J. Doe	